Florida HEALTH
Palm Beach County

DOH-PBC Special Event Registration Form For: ZIKA

To be filed under eligibility

Part-1: Client Information

Last Name	First Name	Middle Name	Suffix

Date of Birth: (mm/dd/yyyy)	**Language (✓):** □ English □ Spanish □ Creole □ Other (Specify):	**Gender (✓):** □ Male □ Female □ Transgender-Gender at birth: □ Male □ Female
Email:	**Country of Birth (✓):** □ USA □ Other (Specify):	Date to USA:

Race: Check (✓) all racial categories that apply: □ Black or African American □ White □ American Indian or Alaska Native □ Asian □ Native Hawaiian □ Other Pacific Islander □ Japanese □ Chinese □ Guamanian or Charmorro □ Filipino □ Vietnamese □ Korean □ Samoan

Hispanic? □ Yes □ No If yes, select one □ Mexican or Mexican American or Chicano/a □ Puerto Rican □ Cuban □ Another Hispanic or Latino/a or Spanish origin

Were you a single birth? □ Yes □ No	If NO, are you a: □ Twin □ Triplets □ Other (Specify):	Were you born? □ First □ Second □ Other (Specify):

Living Address:			**Apt#**	**Check (✓) One as your Primary Contact:**
City:	**State:** FL	**Zip Code:**		□ Cell Phone#:
Mailing Address: (If different from where you live)			**Apt#**	□ Home Phone#:
City:	**State:** FL	**Zip Code:**		□ Work Phone#:
Alternate Address for Health Care Communications:			**Apt#**	□ Fax Phone#:
City:	**State:** FL	**Zip Code:**		□ Alternate Phone#:

Part-2: Emergency Contact

First Name:	Last Name:
Phone # □ Cell □ Home □ Work	Relationship:

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY CONSENT TO THE PALM BEACH COUNTY HEALTH DEPARTMENT, TO VERIFY THE INFORMATION PROVIDED.

Client/Parent/Guardian Signature: □ Client □ Parent □ Guardian Date:

PBCHD Official Use Only: Registered by:_____ **Date:**_____

Facility: □Belle Glade □Centering Program □Delray □Jupiter □Lantana/LW □Northeast □WPB